

SOMALI BANTU HEALTH SHEET

Colonial rule divided the Somalis from the mid-1800s until 1960, when two territories were reunited to form modern Somalia. Somalia's government fell in 1991 after opposition from clan-based militias and three years of civil war. Since then, there is no government. Mass starvation has ensued and the level of violence is extreme with rape and torture commonplace. An estimated 400,000 Somalis died during this period, and at least 45% of the population has been displaced by the fighting. Many Somalis still remain in refugee camps, some have been repatriated and several thousands have been resettled to the U.S. and Europe. In the spring of 1994, all foreign troops had been withdrawn due to the instability. Resettlement programs have enabled families to move to Europe and the United States.



Source: [Http://www3.baylor.edu/~Charles_Kemp/somali_refugees.htm](http://www3.baylor.edu/~Charles_Kemp/somali_refugees.htm)

Pre-migration	During flight & refugee camps	Post-migrational & Resettlement
exposure to infectious and parastitic diseases, physical and psychological trauma	malnutrition, exposure to the elements, exposure to infectious and parasitic diseases, physical and psychological trauma	increasing susceptibility to chronic diseases, problems and stressors of resettlement (racism, unemployment, ESOL, crime, etc.)

Upon resettlement in the US, health practitioners should be aware of the following possible medical issues in the Somali Bantu:

- Susceptibility to chronic diseases
 - Stressors
 - Mental health issues
 - Oral Health Deficiencies
 - Gynecologic Complications
 - Nutritional Deficiencies
- Within Kakuma, Somali Bantu health is poor due to a lack of health care information within the community, poverty, limited utilization of public health facilities, and inadequate resources.
 - The Somali have the combined challenges of the after effects of trauma from violence and the intergenerational culture of inferiority and second-class citizen status.
 - The prevalence of violence and constant threat of attack in the refugee camps have further eroded the Somali's sense of security and well-being.
 - IOM reports trauma-related problems, including hopelessness and depression, among the Bantu being interviewed for resettlement. Symptoms of PTSD, depression, anxiety, and physical injuries resulting from torture are prevalent among refugee populations.

Family Structure

- The societal structure is markedly fractionated by membership in patrilineal clans (descent through male lines).
- Men and elder family members are assigned positions of highest respect by religious traditions.
- Loyalty, peace, harmony and health promote the stability of the "*spiritual unity*" of families.
- Cooperation and responsibility of role functioning supports "*social unity*".
- Patterns of family interaction directed women to defer to men, especially in public.
- Loss of extended family support creates increased stress for resettled family members.
- There is a strict separation of the sexes. Women, including prepubescent girls, are expected to cover their bodies, including hair when in public.
- An ideal Bantu family consists of between 4-8 children. The extended family includes grandparents, uncles, aunts, and other relatives.
- A married woman retains membership in her father's family.

- A two-parent family structure describes the ideal form for Somali families. There are words for divorced and widowed women but not for “single mother” (it violates religious family structure).
- Somali family conflict management strategies require arbitration by the elderly.

Reproductive Health

- Contraception and similarly, abortion, are anathema to most Somalis, given the strong Muslim belief that pregnancy is a blessing from God.
- Sexing of the fetus is not encouraged as it is God’s will and cannot be changed.
- Most women fear Caesarean section delivery, as it is thought that the surgery may impede subsequent pregnancies.
- Specific to Bantu women, the experiences of circumcision, rape, lack of education, second-class status in Somali society, high birth rates, single parent status and trauma from past experiences requires appropriate social services, ensuring as much as possible that people belonging to the same social support network are resettled in the same geographic location.
- Female Genital Mutilation (FGM) is performed throughout Somalia on girls between the ages of four and ten, and has a prevalence of over 95%. Infibulation, the extreme form of FGM, is the most common cause of difficult or prolonged delivery, and is one of the main causes of maternal mortality. It affects the physical, mental and psychosocial wellbeing of girls and women.
- Gynecologic complications may occur as a result of Female Cutting (FC) / Female Genital Mutilation (FGM): tetanus, chronic pelvic infection, urinary tract infection, infertility, incontinence, difficulty with urination and menstruation; obstetric complications of FC/FGM: severe perineal lacerations, obstructed labor, fistulas, and uterine rupture.
- Women may experience difficulty with sexual intercourse because of the reduced size of the introitus, or vaginal opening. For the same reason, pelvic exams may be physically painful and difficult.
- The history of sexual abuse among many refugee women may evoke strong emotional and psychological responses to gynecological exams.
- In the USA, Somali refugees seek pre-natal care. There is a preference for female examiners. Bantu women will be further challenged if they cannot draw upon their extended family and kin networks to assist them with child rearing and moral support.

Antenatal and postnatal care

- Poor antenatal and postnatal care, with the almost complete lack of emergency obstetric referral care for birth complications, further contribute to these high rates of mortality and disability.

Maternal and Child Health

- In Somalia, current indicators relating to children and women's welfare almost universally demonstrate a deterioration over the stats as measured before the war period.
- There is a high birth rate among this population: 29% of deliveries in Kakuma since July 2002 were Somali Bantu while this community represents only 12% of the total population of the camp. Data from UNICEF notes that maternal mortality (MMR) is estimated at 1600 per 100,000, placing Somali women among the most high-risk groups in the world. Nonetheless, approximately 1 in 48 women is at risk of dying from a pregnancy or childbirth related complication. Because Somali women do not practice birth spacing, the mortality rates in infants is high and the prevalence of low birth weight infants is common.
- Haemorrhage, prolonged and obstructed labour, infections and eclampsia are the major causes of death at childbirth.
- Anaemia and female genital mutilation (infibulation) have a direct impact on, and aggravate these conditions.
- There is a high prevalence of low birth weight infants. Nineteen percent (19%) of Somali Bantu infants born in Kakuma since July 2002 had a low birth weight.
- Women may reduce their food intake in order to limit the size of their baby in order to prevent a difficult birth after experiencing female circumcision/female genital mutilation.
- Anemia is common among pregnant women in Somalia. Malaria and other parasitic diseases can cause severe disease or worsen pre-existing iron deficiency anemia.
- Women often stop breastfeeding as soon as they become pregnant and start weaning their children before the recommended age of 6 months.
- Breastfeeding is common but the feeding is usually supplemented with animal milk (camel, goat or cow). The animal milk is offered with a cup rather than a bottle.
- Quality of care is affected when a mother must also attend to a high number of young siblings. Malnutrition in these children may result from chronic disease exacerbated by inappropriate food intake and caring practices.

- The rates of child morbidity and mortality in Somalia remain among the highest in the world. A survey undertaken in 2000, the Multiple Indicator Cluster Survey (MICS) estimates the infant mortality rate (IMR) at 132 per 1000 and under five years old mortality rate (U-5MR), 224 per 1000. (UNICEF). Leading health problems of Somali Bantu children are pneumonia (41% of deaths), malaria (24.5% of deaths) and watery diarrhea (16.9% of deaths).

Child Birth

- Childbirth most often takes place at home, attended by a midwife. The new baby and mother stay at home for 40 days after birth, with female relatives and friends helping to care for both.
- Newborn care includes warm water baths, sesame oil massages and passive stretching of the baby's limbs.
- Diapering is not common in Somalia. When the baby is awake, the mother holds the baby in a sitting position over the basin. At night, a plastic is placed between the mattress and the bedding. The bedding and plastic are cleaned daily. Somali mothers say infants are toilet-trained in a short period of time.

DIET AND FOOD

- Due to the diet of the group (mostly maize, known as “soor”, which is a thick porridge), beans, sorghum, lentils, some vegetables and fruit, there are micronutrient deficiencies. In the USA, those refugee families coming from Western and Central Africa continue their traditional diet eating no less than twice a day rice, Fufu (a starchy accompaniment for stews or other dishes with sauce), cassava and plantains.
- Deficiency diseases include, in addition to the most common Fe and vitamin A deficiencies, scurvy (vitamin C deficiency), pellagra (niacin and/or tryptophan deficiency) and beriberi (thiamin deficiency).
- Regular supplementation of specific vitamins (e.g. vitamin C, vitamin B complex) is advisable.
- There is a need for dietary diversification. This can only be achieved by counseling refugees regarding healthy diets.

- The Somali's food diet is so different from the USA diet, that only through education, training and counseling can the diet be diversified enough to achieve the desired healthy nutritional outcomes.